

## PROVIDER COVID-19 IMMUNIZATION CONSENT FORM

**For COVID-19 Provider Use Only** Clinic Name/Code: \_\_\_\_\_  
 Location type:(clinic, health department, pharmacy, etc.,) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date of Service: \_\_\_\_\_

### Person Receiving Vaccine:

**(Legal) First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Date of Birth:**   /   /

**1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.**

**If you answer "YES" you may not be able to receive the COVID-19 vaccine.**

If YES refer to Pfizer website at <a href="http://www.PfizerMedInfo.com">www.PfizerMedInfo.com</a> . Moderna COVID-19 vaccine <a href="http://www.modernatx.com">www.modernatx.com</a> . Janssen COVID-19 vaccine <a href="http://www.janssencovid19vaccine.com">www.janssencovid19vaccine.com</a> . Refer to Pre-vaccination Checklist for COVID-19 Vaccines Information for Healthcare Professionals ( <a href="http://cdc.gov">cdc.gov</a> ) to clarify further questions: <a href="http://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf">www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf</a> .	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, what type and date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had an allergic reaction to a COVID-19 vaccine or a COVID-19 vaccine component (including polyethylene glycol [PEG], which is found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate, which is found in some vaccines, coated tablets, or IV steroids)?		
Have you ever had an immediate allergic reaction of any severity to any vaccine or injectable therapy? This would include an anaphylactic reaction that required treatment with epinephrine (or EpiPen) or treatment at a hospital, as well as an allergic reaction that occurred within 4 hours, such as difficulty breathing, hives, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.		
Have you ever had a severe allergic reaction (anaphylaxis) to something other than a component of COVID-19 vaccine or any vaccine or injectable medication, such as food, pet, venom, environmental, or oral medication allergies?		
Do you have a bleeding disorder or are you taking a blood thinner?		
Do you have dermal fillers? If swelling occurs at or near the filler injection site, usually face or lips, patient should contact their health care provider.		
Are you pregnant, breastfeeding, planning to become pregnant? Women in this group may receive any FDA-authorized COVID-19 vaccine. Women 18 through 49 years of age can receive any FDA-authorized COVID-19 vaccine and should be informed of the increased risk of thrombosis with thrombocytopenia syndrome (TTS) after receiving Janssen COVID-19 Vaccine and the availability of other (mRNA)COVID-19 vaccines.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are still eligible to receive Pfizer-BioNTech, Moderna, or Janssen COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counseling about the vaccine.		
Have you had history of heparin-induced thrombocytopenia? If it has been 90 days or less since illness resolved, you may receive Pfizer-BioNTech or Moderna COVID-19 vaccine. After 90 days since illness resolved, you may be vaccinated with any FDA-authorized COVID-19 vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Have you had Multisystem Inflammatory Syndrome (MIS)? Pfizer-BioNTech, Moderna, or Janssen COVID-19 vaccination should be deferred for at least 90 days to avoid interference with vaccine-induced immune responses.		
<b>NOTE:</b> Recipients of Janssen COVID-19 vaccine should be instructed to seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, neurological symptoms (including severe or persistent headaches or blurred vision), nausea, vomiting, petechiae, or easy bleeding beyond the site of vaccination within 4 to 30 days of receipt of Janssen vaccine. Most people who have developed blood clots and low platelets were females ages 18 through 49 years.		
<b>NOTE:</b> Depending on vaccine type, a second dose of COVID-19 vaccine <b>may</b> be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your vaccination provider, PCP, or your ADH Local Health Unit in 21 days or 28 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Janssen COVID-19 vaccine is a ONE dose series.		

**2. RELEASE AND ASSIGNMENT:**

Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right.

**Please sign here** →

My signature below indicates I have read, understand, and agree to section 2. **Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

**Signature of Patient/Parent/Guardian:**

Date \_\_\_\_\_

